907 KAR 3:140. Coverage and payments for the Health Access Nurturing Development Services (HANDS) Program.

RELATES TO: KRS 194A.030(2), 205.520, 211.690, 42 U.S.C. 1396a-d, 1396n(g)
STATUTORY AUTHORITY: KRS 194A.050(1), 205.520(3), 205.560, EO 2004-726
NECESSITY, FUNCTION, AND CONFORMITY: EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services. The Cabinet for Health and Family Services, Department for Medicaid Services, has the responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet by administrative regulation to comply with any requirement that may be imposed, or opportunity presented by federal or state regulation for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes requirements for coverage and payment for Health Access Nurturing Development Services (HANDS) provided through an agreement with the state Title V agency, the Department for Public Health.

Section 1. Definitions. (1) "Department" means the Department for Medicaid Services or its designated agent.

(2) "Title V agency" means the Department for Public Health.

(3) "HANDS" means health access nurturing development services provided in accordance with 902 KAR 4:120.

(4) "Recipient" is defined in KRS 205.8541.

(5) "Partnership" means an entity that meets the criteria established in 907 KAR 1:705, and under contract with the department in accordance with KRS Chapter 45A, agrees to provide, or arrange for the provision of health services to members, on the basis of prepaid capitation payments.

(6) "KenPAC" means the Kentucky Patient Access and Care System which operates as primary care case management system in accordance with 907 KAR 1:320E.

(7) "Managed care organization" means the risk-bearing managed care organization that provides physical or behavioral health services through provider networks on a prepaid basis as either a health maintenance organization or a provider sponsored integrated health care delivery network.

Section 2. Covered Services. (1) Services shall be provided pursuant to an interagency agreement between the department and the Title V agency.

(2) Except for a screening service as established in 902 KAR 4:120, Section 4(1), HANDS services shall be provided to a recipient who meets the eligibility requirements for HANDS as established in 902 KAR 4:120, Section 2.

(3) Medicaid services to be provided shall be the case management services described in 902 KAR 4:120, Section 4(2) through (6).

Section 3. Provider Qualifications and Conditions for Participation. (1) Services shall be provided by the Title V agency:

(a) Directly; or

(b) Indirectly through a subcontract that requires a subcontractor to meet the provisions of 902 KAR 4:120, Section 3(2).

(2) If a HANDS service is provided to a recipient who is a member of a Medicaid managed care partnership, managed care organization or KenPAC, a provider of service shall coordinate and exchange information with the recipient's primary care provider.

Section 4. Reimbursement. (1) Payments shall be based on the cumulative cost of providing the service.

(2) An interim rate based on projected cost shall be used with a settlement to cost after the end of the state fiscal year.

(3) A HANDS provider that meets the criteria in 902 KAR 4:120, Section 3(2), shall have on file an approved cost allocation plan.

(4) Interim rates for services provided in accordance with 902 KAR 4:120, Section 4(2) through (6), shall be based on the:

(a) Type of service;

(b) Personnel providing the service;

(c) Amount of time required to provide the service; and

(d) Costs related to providing the service, including:

1. Contacting other persons in agencies who may be familiar with the family's circumstances;

2. Telephone contacts; and

3. Indirect costs, including:

a. Utilities;

b. Building space;

c. Travel expenses; and

d. Office administration.

(5) An annual cost report shall be submitted to the Department for Medicaid Services within 180 days after the close of the fiscal year.

(6) Interim payments shall be adjusted to actual cost based upon review and acceptance of the cost report by the department.

(7) The provider may submit for consideration an amended cost report for a fiscal year up to twenty-four (24) months after the close of that fiscal year. (27 Ky.R. 1126; 1495; eff. 12-21-2000; Crt eff. 12-6-2019.)